TITLE: **Treatment Planning and Review**	POLICY NUMBER: **13.1**	EFFECTIVE DATE: **1/2026**
CARF REFERENCE: **Person-Centered Plan 2.C.3**	PAGE NUMBER: **1 of 3**	**General Program Standards**

SE: To ensure each client receives complete and appropriate service planning assuring that treatment is appropriate to client needs.

PROCEDURE:

- Upon admission, the Primary Therapist will ask the client what his/her goals/plans for treatment are and will reflect that information in the admission note;
- The client's Primary Therapist will provide and/or coordinate the individualized treatment plan;
- The Primary Therapist will utilize the referral sources, family members, clinical team and client interview in determining client's needs and the development of goals for services;
- The treatment planning process will be holistic in approach focusing on all domains that impact on the client (i.e.: recovery issues, vocational, educational, housing, relationships, etc);
- In developing a client's treatment plan, the Primary Therapist will utilize client input ascertained during focused interviews, as well as the input of family members via phone conversations, family therapy and informal interviews;
- Client and family will receive education and be provided with information regarding symptoms, effects, and treatment of mental illness, medications, substance abuse; co-dependency and its effect on substance abuse treatment; the implementation of self-care rehabilitation (including, but not limited to, Alcoholics Anonymous, Al-Anon, Narcotics Anonymous, Nar-Anon, Alateen) and community agencies/resources available during treatment services. Clinical team will provide above mentioned education and information;
- The treatment plan will include goals, timeframes, measurable objectives that relate to the goals and specific criteria for termination or reduction in services;
- The treatment plan will be completed within 24 hours of admissions;
- Client's treatment plan will be evaluated on a monthly basis by the multidisciplinary team during morning Clinical Meetings;

- Criteria for a decrease in services or discharge include: The client has achieved the goals articulated in his/her treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Or the client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Or the client has demonstrated a lack of capacity to resolve his/her problem(s). Or the client has experienced an intensification of his/her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care;

- Before completion of treatment and discharge from facility, Clinical team will secure referrals to community agencies and resources for aftercare, as assessed and developed by client and multidisciplinary team;

- Clinical Team will utilize representatives of support groups including, but not limited to, Alcoholics and Narcotics Anonymous, to secure sponsorship and/or contacts to accompany clients to support groups prior to discharge;

- For clients who are receiving medication monitoring, that is to be included in the treatment plan;

- The client is to sign the treatment plan as an indication of client's participation in the development of the treatment plan.

Treatment Planning Review

SE: To ensure each client receives treatment that is appropriate to the client needs recognizing changing needs and progress

PROCEDURE:

- The treatment plan will include goals, timeframes, and measurable objectives that relate to the goals and specific criteria for termination or reduction in services;

- The treatment plan will be completed by within 24 hours of admission;

- Clients treatment plan will be reviewed at each individual session to evaluate the progress of the client;

- Client's treatment plan will be evaluated on a monthly basis by the multidisciplinary team during morning Clinical Meetings;

- The weekly progress notes will reflect progress or lack of progress in the accomplishment of the goals;

- In the treatment plan review meeting, the team will determine if there has been sufficient progress in the identified goal area;

- If the client is having difficulty with progressing in any goal area, the Primary Therapist and the client will discuss if the interventions/methods need to be adjusted or if the goal needs to be modified or discontinued;

- Client will develop new goals as requested by the client, suggested by the team and agreed to by the client and in response to a changing situation;

- Criteria for client a decrease in services or discharge include: The client has achieved the goals articulated in his/her treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Or the client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Or the client has demonstrated a lack of capacity to resolve his/her problem(s). Or the client has experienced an intensification of his/her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care;

- Before completion of treatment and discharge from facility, Clinical Team will secure referrals to community agencies and resources for aftercare, as assessed and developed by multidisciplinary team.